

Nottinghamshire Joint Formulary Group Meeting Minutes

Thursday 15th July 2021, 2-5 pm

On line Microsoft Teams meeting due to COVID-19

Present:

David Wicks (DW), GP and Local Medical Committee (Chair)
 Steve Haigh (SH), Medicines Information Pharmacist, SFHFT
 Esther Gladman (EG), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
 Lynne Kennell (LK), Interface/Formulary Pharmacist, SFHFT
 Shary Walker (SW), Interface/Formulary Pharmacist, NUH
 Laura Catt (LC), Prescribing Interface Advisor, NHS Nottingham and Nottinghamshire CCG
 David Kellock (DK) Consultant, Sexual Health, SFHFT
 Asifa Akhtar (AA), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
 Tanya Behrendt (TB), Senior Medicines Optimisation Pharmacist NHS Nottingham and Nottinghamshire CCG
 Tim Hills (TH), Assistant Head of Pharmacy, NUH

In attendance:

Dr Gillian Sare, Consultant Neurologist NUH (joined at 2.50 pm for item 5a)

Apologies:

Karen Robinson (KR), APC/Interface/Formulary Support Technician, NHS Nottingham and Nottinghamshire CCG
 Jill Theobald (JT), Interface Efficiencies Pharmacist, NHS Nottingham and Nottinghamshire CCG
 Irina Varlan (IV), Interface Efficiencies Pharmacist, NHS Nottingham and Nottinghamshire CCG
 Hannah Godden (HG), Mental Health Interface Pharmacist, Nottinghamshire Healthcare Trust
 Debbie Storer (DS), Medicines Information Pharmacist, NUH
 Kuljit Nandhara (KN), Deputy Chief Pharmacist, Head of Pharmacy Mental Health Services, NHCT
 Matthew Elswood (ME), Chief Pharmacist, Nottinghamshire Healthcare Trust
 Steve May (SM), Chief Pharmacist, SFHFT

Agenda item	Notes
1. Apologies	Noted (see above).
2. Declarations of interest	Nothing was declared by members of the group. Lisa Waddell, submitter for Elecare [®] infant formula (Abbott), declared membership of a scientific steering committee for Abbott and the undertaking of aid work/receipt of sponsorship from all of the hypoallergenic formula companies.
3. Minutes of the previous meeting	The minutes were accepted as an accurate record of the meeting.
4. Matters arising and Action Log	Matters arising: Bimatoprost & timolol, Eyzetan[®] LK will attempt to obtain ophthalmological views again on preferential use vs UDVs. ACTION: LK to pursue discussions with ophthalmology. Agomelatine (generic)

	<p>This was a new application at the last JFG. APC had approved the reclassification of agomelatine as amber 2 as a fourth-line option for the treatment of major depression in adults where other antidepressants have proven ineffective or poorly tolerated, but an information sheet had been requested. ACTION: HG to provide Agomelatine Information Sheet and bring to APC.</p> <p>Cinacalcet This was reclassified to Amber 2 in June 2020 for hyperparathyroidism, but the significant increase in usage was potentially beyond what had been anticipated. LK showed the usage graph of cinacalcet in the last 6 months, which was growing considerably. Concerns were raised regarding the increasing number of prescriptions and the cost pressure that this may bring, and therefore, suggested that perhaps it was necessary to audit its use. A comparison to other areas of the country was suggested and data from OpenPrescribing suggested that cinacalcet prescribing in Nottinghamshire was currently at the lower end of the prescribing range compared to other CCGs. ACTION: LK to discuss patient numbers with original submitters and request a forecast for future prescribing.</p> <p>Magnesium Kora Healthcare 4mmol (97 mg) tablets An unlicensed special is currently being used, however, there is now a licensed preparation and the price had been confirmed as less expensive than the current preparation. ACTION: LK to add the licensed product to the formulary.</p> <p>Mesalazine 1g suppositories, Octasa® Octasa had been agreed as first line mesalazine suppository. There is some reluctance from gastroenterologists to switch existing patients so active switching is not being pursued currently. ACTION: LK to update JFG with outcome of further discussions.</p> <p>** All other items were either completed or included on the agenda. **</p>
<p>5. New applications</p>	<p>a) Safinamide (Xadago®, Profile Pharma)- Dr Gillian Sare joined at 2.50 pm.</p> <p>SW presented the safinamide submission to the group. The submission was a request to modify the use of safinamide, extending the indication to allow its use for off periods without dyskinesia as an adjunct to levodopa. This is in line with its licensed indication.</p> <p>In November 2016, safinamide was approved with an Amber 2 classification with the restriction to patients with motor fluctuations experiencing off-periods and dyskinesia. Despite it being expensive, safinamide may confer a cost-saving for this cohort as due to its dual functionality it may replace two agents (MAO inhibitors and amantadine), and reduce the tablet burden. Dr Gillian Sare joined the meeting and discussed the following points:</p> <ul style="list-style-type: none"> - Safinamide 50mg is a monoamine oxidase inhibitor type B which increases dopamine at the synapse and helps the off-symptoms in Parkinson's disease. At a dose of 100mg, safinamide has an anti-glutamate effect, which has a particularly anti-dyskinetic effect. It is an incredibly useful adjunct in terms of improving quality of life and preventing off periods. - The other MAO-B inhibitors are selegiline and rasagiline. From a clinical

perspective, selegiline is clinically effective but poorly tolerated. A large group of patients do not tolerate selegiline. Patients may experience hallucinations, feel unwell, and therefore, it has very limited use. Alternatively rasagiline, in clinical practise has been demonstrated to be clinically ineffective. This is also acknowledged in the NICE guidelines.

- Selegiline 1.25mg sublingual tablets were previously used and this preparation was better tolerated and worked well. However, the product had been discontinued, leaving only standard selegiline. A 10mg dose is necessary for clinical effectiveness, but a reasonable number of patients are unable to tolerate this dose. Conversely, safinamide had been found to be useful in the elderly and quite frail patients with Parkinson's disease. It was better tolerated and worked well particularly from a cognitive perspective in this patient cohort.
- Entacapone could be considered another alternative, but it may be too potent for some patients and dosing may be complicated with multiple daily dosing. Using safinamide is not complicated as it is used once a day and works well, reducing the tablet burden in this patient cohort.
- Selegiline is currently being used in younger patients, however, due to its long list of contraindications and side effects, e.g. cardiac problems and amphetamine-like metabolites, the specialists would prefer to use safinamide in this patient group also.

SH queried the measurable price difference between selegiline and safinamide. Dr Sare suggested using selegiline first line in patients under 70 years without any cognitive impairment and to continue treatment if effective and tolerated as a compromise. If the treatment fails, the patient can then be switched to safinamide. Additionally, Dr Sare explained that selegiline would be avoided in frail and elderly patients due to the risk of harm.

LC raised the concern of the possibility of going over the financial threshold of the APC's mandate if the predicted number of patients mentioned in the submission is in addition to existing patients on safinamide.

Dr Sare explained that NUH is a tertiary referral movement disorder service and therefore, see more patients with Parkinson's compared to other centres. Moreover, Dr Sare clarified that there were no guidelines on managing Parkinson's Disease because it is such a combination of experience and shared decision making with the patient. Additionally, dopamine agonists and levodopa preparations remained the absolute mainstay of the management of Parkinson's disease.

JFG suggested comparing the clinical practice to other tertiary centres (Leeds, Birmingham, Manchester) and comparing safinamide prescribing between ICPs to gain clarity about the influence of NUH's prescribing.

JFG felt that delaying people from getting dyskinesia, keeping them out of hospital and keeping people at work were very compelling arguments but difficult to factor in economically.

ACTION: SW to contact specialists from other tertiary centres to compare clinical practice (e.g. use of rasagiline, safinamide and selegiline), then discuss at APC.

b) Elecare[®] infant formula (Abbott)

The Cow's Milk Allergy (CMA) guidelines are being updated by the submitter. It

	<p>had initially been requested that Elecare is added as first choice option for severe CMA in place of SMA Alfamino. However, following the discussions with the NUH Allergy Team, it was felt that some experience should be gained with the product before recommending it first-line. Therefore, the request has been changed to an Amber 2 classification to allow continued prescribing in primary care after specialist recommendation so that experience can be gained with the product.</p> <p>LK explained that there was no published comparative evidence to support individual products, but it is at least cost neutral and potentially less expensive than current alternative options.</p> <p>LC highlighted the submitter's declaration of interest and queried whether there had been any independent consultation. LK had sought feedback from secondary care clinicians and dieticians and it was suggested that Matt Lawson (Medicines Optimisation Dietitian) be contacted for a view.</p> <p>TB questioned the product's claim on clinical benefits from innovative ingredients and the evidence that supports these claims.</p> <p>ACTION: LK to contact Matt Lawson for a viewpoint and take to APC for an Amber 2 classification.</p> <p>c) Budesonide orodispersible (Jorveza[®], Dr Falk Pharma)- NICE TA</p> <p>A red classification had previously been assigned following a formulary application in 2019 due to the expectation of an imminent publication of a NICE TA at that time.</p> <p>The NICE TA was delayed, but has now been published and recommends budesonide as an orodispersible tablet (ODT) as an option for inducing remission of eosinophilic oesophagitis in adults.</p> <p>LK explained that although the formulary entry is in line with the NICE TA, the clinicians wish to pursue an Amber 2 classification. Since the original submission, there had been a license extension to allow its use for maintenance treatment. However, this has not been included in the NICE appraisal. Clinicians felt that although the numbers of patients that may require maintenance treatment are small, it would be beneficial for these to receive prescriptions in primary care.</p> <p>Further clarity was requested regarding the duration of maintenance treatment and when transfer of treatment to primary care would occur as specialist assessment is required to assess response.</p> <p>Discussion was had regarding the appropriateness of primary care prescribing given the small patient numbers. However it was felt that this should not be a barrier in this instance because of the wide usage of budesonide and steroids in other formulations.</p> <p>ACTION: LK to seek clarity as above on the duration of maintenance treatment and take to APC.</p>
<p>6. Formulary amendments</p>	<p>FOR INFORMATION - Log of minor amendments carried out</p> <ul style="list-style-type: none"> • Buprenorphine- Added clarification - Amber 2 for GPs with special interest commissioned by public health to provide substance misuse services.

	<ul style="list-style-type: none"> • Methadone 1mg/1mL oral solution- Added clarification - Amber 2 for GPs with special interest commissioned by public health to provide substance misuse services. • Buprenorphine injection- Added to formulary as RED - restricted to use by commissioned community SMS providers only (currently CGL Nottinghamshire County). • Clonazepam- Added clarification - Specialist initiation for the treatment of REM sleep disorders in patients with Parkinson's Disease in line with NICE Guideline and previous APC discussions. • Ephedrine 0.5 and 1% Nasal drops- discontinued - changed to non-formulary. • Insulin aspart- Added the names FlexPen and FlexTouch to the formulary to clarify devices available. <p>FOR DECISION - Suggested amendments</p> <ul style="list-style-type: none"> • Entonox- Currently green, recommendation to reclassify as red. Although this is used in primary care, it is by specialist services and there have been queries around primary care prescribing. • Levothyroxine liquid- recent MHRA advice advocates switching to a liquid formulation if symptoms or poor control persists on a consistent formulation of tablets. However, this would be associated with a considerable cost implication and advice includes patients that are biochemically euthyroid. JFG suggested that some guidance on managing potential patient requests for this may be helpful and requested a specialist opinion. Action: SW to seek specialist opinion. • Dexamethasone 0.1% eye drops- Supply problem with these and Eythalm (most cost effective preservative free option). Awaiting specialist opinion for management of these patients. Action: LK/SW to pursue specialist opinion as primary care patients will require a switch in therapy • Varenicline- This is currently unavailable. Smoking cessation services are aware and it shouldn't routinely be prescribed in primary care because of commissioning arrangements. Action: Check optimise message/ formulary reflect the prescribing situation <p>ACTION: SW to address above points and take to APC</p>
<p>7. Horizon scanning</p>	<p>New publications for review</p> <p>Fosfomycin trometamol, Alexi® 3g granules for oral solution- this is prescribed generically so no further action required.</p> <p>Alimemazine sugar-free (Zentiva Pharma) This sugar-free solution is more cost effective than our current product of choice. However, there is a syrup form which is even more cost-effective. Recommendation to adopt this product as long as sugar content is considered acceptable. ACTION: LK to check the sugar content is acceptable.</p> <p>Insulin Aspart, Trurapi® (Sanofi) Biosimilar to Novorapid® and will be made available to the NHS at a 30% price reduction to the current originator insulin aspart list price. ACTION: Discuss with the diabetes team</p>

	<p>Action Reliever, Thuasne® A new device marketed for osteoarthritis. GP's have received patient requests for this device and the company website is very proactive at encouraging patients to pursue prescriptions. TB shared that one area has issued advice that any potentially eligible patients should be formally reviewed by the specialist team and therefore it is inappropriate for the device to be prescribed in primary care. ACTION: SW/ LK to seek specialist opinion on whether similar advice could be added to the formulary alongside a grey classification.</p> <p>Dapagliflozin, Forxiga® A UK license extension for the treatment of chronic kidney disease in adults is expected soon. A NICE guideline is due to be published in August that recommends SGLT2 use for patients with Type 2 diabetes and an ACR>30mg/mmol. Costing work is currently ongoing to determine the cost impact but a significant cost pressure is anticipated. Recommendation: Add as Grey no formal assessment for this indication.</p> <p>NICE Guidelines, TAs and Evidence summaries</p> <p>All Noted</p>
<p>8. Definition of RED classification</p>	<p>Our current definition of RED drugs states "Patients already receiving red drugs in primary care can continue. No new patients to receive prescriptions in primary care." Opinion on rewording the definition was sought. JFG recommended that the definition be changed to "No new patients to receive prescriptions in primary care. Patients already receiving Red medicines in primary care should be handled on a case by case basis. Advice from the Medicine Optimisation team is available."</p> <p>ACTION – KR/LK to update all reference to this definition</p>
<p>9. Fentanyl patches</p>	<p>As part of the opioid guideline for non-cancer pain review, it was highlighted that the Opioidur® brand is more cost-effective in primary care with a significant saving of £47,000 per quarter. However, it was noted that this might cause a cost pressure within secondary care (the cost pressure for switching from Matrifen to Opioidur for NUH: £7,000, and for SFH: £5,000). The patches are bioequivalent and therefore switching is not expected to be a problem from a clinical perspective.</p> <p>The group felt that it would be appropriate to switch brands as the savings to the health community as a whole could be significant. Trusts could prescribe generically and would consider switching internally.</p> <p>ACTION: LC to check that no differences between patches from a patient perspective that may influence switching and bring to APC.</p>
<p>10. Dates of next meeting</p>	<p>16th September 2021 (Via Microsoft Teams) EG is unavailable so requested that another member chairs the meeting.</p>

The meeting finished at 15:50pm